

Selected Cases

—FROM THE—

SURGICAL ≈ CLINIC

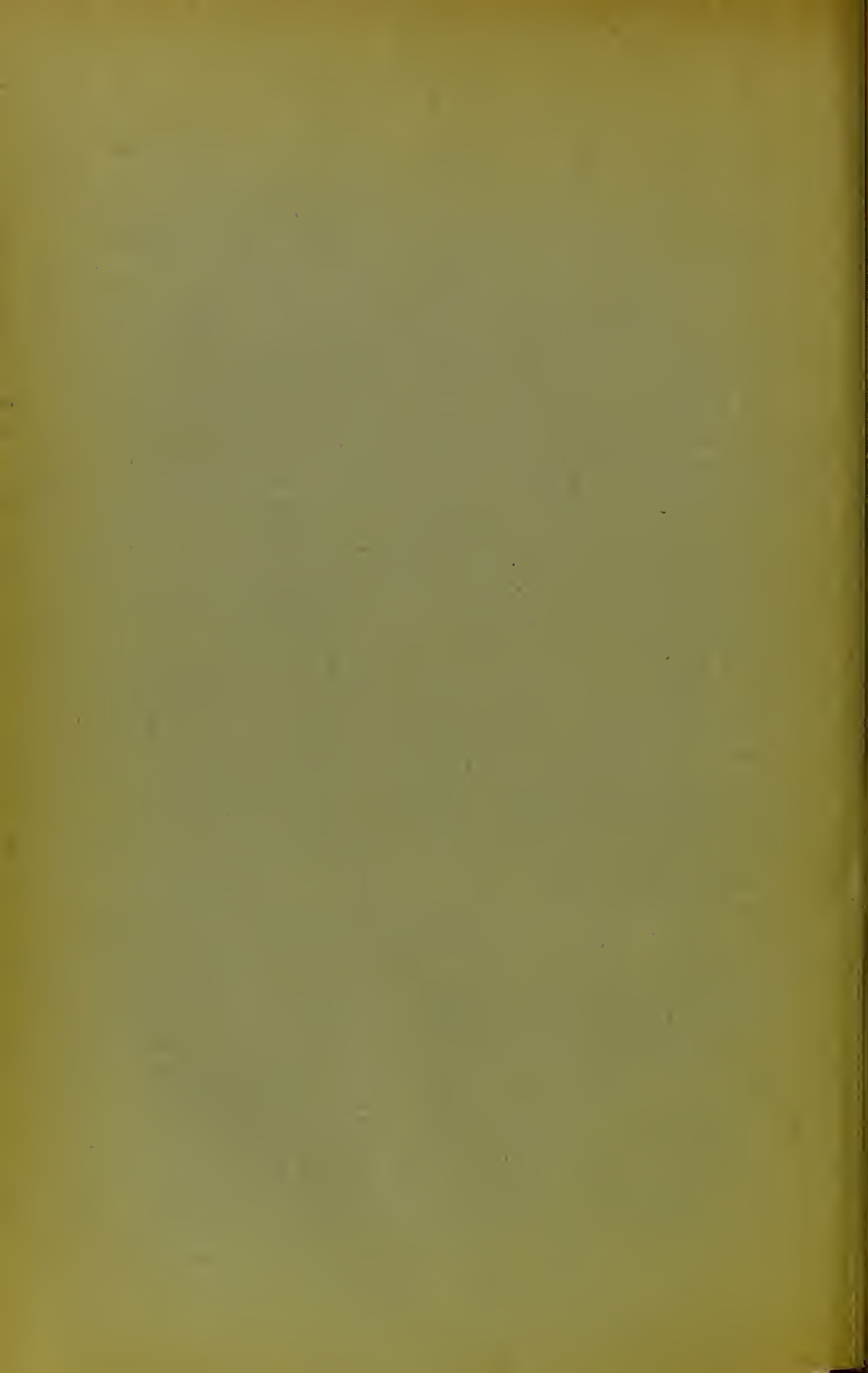
—OF—

FREDERIC S. DENNIS, M. D.

PROFESSOR OF THE PRINCIPLES AND PRACTICE OF SURGERY IN THE BELLEVUE HOSPITAL
MEDICAL COLLEGE, NEW YORK CITY.

Reported by Dr. Thomas McCann, Junior Assistant, Bellevue Hospital.

[Reprint from the *Pittsburgh Medical Review*.]



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SELECTED CASES FROM THE SURGICAL CLINIC OF FREDERIC S. DENNIS, M. D.

PROFESSOR OF THE PRINCIPLES AND PRACTICE OF SURGERY
IN THE BELLEVUE HOSPITAL MEDICAL COLLEGE,
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REPORTED BY DR. THOS. M'CANN, JUNIOR ASSISTANT,
BELLEVUE HOSPITAL.

(*First clinic, October, 1886.*)

GENTLEMEN: The first patient that I shall introduce to you this afternoon is one with the following brief history.

CASE I. J. Mc. J. *æt.* 26, fireman by occupation, began to suffer pain in his left tibia about a month ago, and since that time a painful lump has developed over the upper part of the tibia. An examination of the limb shows that there is no superficial abscess in the soft parts, that there are no indications of a malignant growth, and that the joint is not involved. Deeply seated pain, increasing in severity at night, with the absence of any signs of malignant growth, points to a periostitis, or to an abscess in the bone itself. As the pain is deeply situated and throbbing in character, I believe the case to be one of abscess in the head of the tibia. The patient has been placed under the influence of ether, and I make an incision in the soft parts down to the bone, push the periosteum aside and place a large trephine upon the crest of the tibia. A disc of bone having been removed, you can all see the pus welling up in the outlet thus given. My diagnosis was therefore correct. I now scrape the walls of the abscess cavity with a Hebra's scoop, wash it out thoroughly with the bichloride solution, and leave a drainage tube inserted into the cavity. As soon as the antiseptic dressing is applied, the patient will be ready to be returned to the ward.

CASE II. The next case, gentlemen, is that of a boy with the following history:

E. L. was admitted to the hospital without any history beyond the fact that the left knee was injured by a fall five years ago. I find uniform chronic swelling over the left knee,

with bony outline marked, and the movement of the joint restricted, extension of the leg beyond an angle of 135° being impossible. Last April I divided the left hamstrings, and applied Buck's extension, with but little improvement as regards straightening the limb. Again, in May, I explored the joint by a transverse incision, removed the patella and found a disorganized abscess in the internal condyle. A thin slice of bone was sawn from the head of the tibia, the condyles of the femur were removed, the diseased structures about the joint were dissected out, and the limb was brought to an almost straight position, but the bones were not wired. A drainage tube was left through the entire length of the wound, which was closed by a continuous catgut suture, all antiseptic precautions being employed. As I now find considerable motion between the parts, I have decided to resect again the joint, and this time to wire together the ends of the bones. I make a long transverse incision over the joint and forcibly flex the leg. I find here a small abscess in the head of the tibia which I scrape out. I saw off the extremities of the bones and wire them together, drilling through their external aspects. Having thus united the two bones in a nearly straight position, I close the wound with catgut, after establishing free drainage. We now apply the antiseptic dressings, and over all a plaster of Paris splint.

CASE III. The next case is one of fracture of the patella. The patient, L. S., *æt.* 25, single, by occupation a butcher, states that while engaged in athletic exercises he attempted to jump, and as he was leaving the ground he felt something "give way." He fell to the ground and was unable to walk unless supported. You can see the knee is slightly swollen and that it is ecchymotic posteriorly, and just beneath my finger is a transverse fracture with about one-half inch separation of the fragments, at the junction of the middle and lower thirds of the patella. I will now make an incision directly over the seat of fracture, parallel with the upper border of the lower fragment, and freely expose the joint. You see that it contains considerable

serum and some blood clots, which I shall wash out. Now I make a short perpendicular incision upwards from the middle of the transverse incision, so as to enlarge the wound, and, lifting up the edges of the aponeurotic covering over the patella, which has fallen between the fragments, I refresh the edges of the fracture with a Hebra's scoop. Then taking the drill I begin on the subcutaneous surfaces near the line of fracture and make a hole in each fragment, and insert a strong piece of silver wire, with the end sharpened to avoid the use of needles. The fragments are brought into perfect coaptation by tightening the wire. A drainage tube is passed through a counter opening at the posterior and outer part of the joint cavity and the edges of the capsule are brought together by suturing. A superficial drainage tube is inserted into each angle of the original incision, which is now to be closed with catgut. Antiseptic dressings are applied as usual, and over all a firm plaster of Paris bandage. The operation has occupied fourteen and a half minutes.

This is a new method of treating fracture of the patella; and onewhich I have adopted in a good many cases during the past two years. There is no danger in the operation, if you are a thorough antiseptic surgeon; but without the practice of careful antisepsis, the operation cannot be performed. I have collected one hundred and eighty-seven cases, and if anyone present desires to study the history, literature and technique of the operation, he can find all the facts in my article published in the *New York Medical Journal*, April 3rd and 10th, 1886. I have operated on many cases since the publication of the article and have no reason to change the views expressed in that paper.

CASE IV. The next case (J. B., female, *æ*t. 52, single), is also one of fracture of the patella. She states that while ascending some steps carrying a heavy tub she fell backwards from the third step, the tub coming down upon her left knee. You can see there is but little swelling or ecchymosis, and about an half-inch separation of the fragments. I proceed precisely as in the case just finished.

(*Second clinic.*)

Gentlemen: The case of trephining for abscess of the head of the tibia, the patient with resection of the knee-joint and the two cases of fracture of patella, will be first dressed in your presence this afternoon, and then I will proceed to operate upon some cases of interest. (The cases alluded to were brought into the theatre, the first dressings removed in the presence of the class, and fresh antiseptic dressings applied. In each case union had taken place in the wounds by primary intention, and no traces of pus were found in any of them. The wounds were all typical of aseptic surgery.)

CASE I. The first case to-day will be an osteotomy for the relief of rachitic deformity.

This patient, F. S., *æ*t. 2½ years, presents a beautiful example of lateral curvature of both legs just above the ankles. I will place the leg upon a sand bag, make a short incision over the point of curvature, and insert my ehisel. I strike the chisel with the mallet several times, then grasp the leg firmly above and below, and fracture both bones. Catgut drains will now be introduced, and the incision closed by continuous suture; antiseptic dressing and a plaster bandage will then be applied.

CASE II. The next patient, J. G., *æ*t. 5, has a curvature of the right femur, producing the so-called *genu valgum*. The curvature is about two inches above the condyles, and fracture of the femur by the same method employed in the last case will remedy the deformity. A hip spica is now applied to this case, for greater firmness and to insure coaptation of the fragments.

CASE III. We now come to the third case to-day of deformity of the long bones due to rickets. The patient is two years old. She presents an anterior curvature of the tibia. I will perform the same operation as in the first case this afternoon. The leg will be enveloped by the plaster as before, great care being taken to keep the wound perfectly aseptic. In cases of anterior curvature, I have been in the habit of dividing the tendo Achillis, thus securing physiological rest to the part during the repair of the fracture. The opera-

tion of osteotomy is perfectly safe if performed under antiseptic precautions. In one afternoon I have performed as many as five in about an hour, each one occupying less than fifteen minutes, and I have never had suppuration occur after an osteotomy. I will remove these splints in your presence in a few weeks, and you will find the fractures firmly united; the wounds will have taken an aseptic course, and the limbs will be straight.

CASE IV. The next patient, (M. V. A., married, *æt.* 32) sent to me by Dr. Burke is a sufferer from carcinoma of the breast; her family history is entirely negative; she has had two misarrriages; her last child was born three months ago, and is healthy. About nine months ago she noticed a hard, kernel-like lump in the left breast, but it grew slowly until after the birth of her child, when it increased rapidly in size. The tumor is large, hard and painful, but with no retraction of the nipple, and no ulceration of the skin. I now make an upper and a lower elliptical incision, and dissect out the whole gland down to the pectoral muscle. This leaves an immense surface to be covered as soon as the bleeding vessels have been tied. After putting in five deep sutures of silk, I will now insert three hare-lip pins, and close the whole with a continuous suture. As you see, a drainage tube has been introduced, and I will now place over the wound an antiseptic dressing, folding the arm over the chest.

(*Third clinic.*)

Gentlemen: The first case to-day is one of *melano-sarcoma*, resembling the case on which I last operated before you, in that both are malignant growths of the breast.

This patient (Mrs. E. D., *æt.* 42, widow), sent to me by Dr. Pell, of Goshen, gives an entirely negative family history as regards malignant disease. Two years and a half ago she bruised her right breast, and since that time pain has been present, which has increased in severity until she has begun to lose weight and strength. If you notice the breast you can see that it is greatly enlarged, and that it is slightly nodular. The nipple

is retracted. The superficial veins are dilated, and just here are two points of fluctuation. I will make my lower incision first, and now the upper incision, continuous at an angle with the lower. I proceed to completely dissect out the gland, down to the surface of the pectoral muscle; having arrested all hemorrhage, I will close the wound by a continuous suture, and dress it as in the other case.

CASE II. The next case is one which presents some points of interest as to diagnosis.

This patient (A. G., *æt.* 67, by occupation a book-binder) gives the following history:—Ten years ago the right side of his scrotum began to swell without apparent cause. This swelling has gradually increased in size, and has never been tapped. Three years ago, while lifting a trunk, the patient felt something give way in his scrotum, and since then has suffered from an inguinal hernia in conjunction with his hydrocele. The patient being now fully anesthetized, we will perform the operation for radical cure of hydrocele.

Taking a scalpel, we make an incision directly over the tumor, and extending down through the sac, and you can see the clear straw-colored fluid pour out. Now, dissecting out a portion of the sac and removing it, we will unite the edges with a quilled suture, and insert a drainage tube in the lower angle of the wound. The usual dressings are applied.

(*Fourth clinic.*)

Gentlemen:—Before beginning the operation in the clinic this afternoon, I will have the osteotomy cases brought into the theatre, also the other cases. All the cases of osteotomy which you saw operated upon last week, are free from local pain, and also free from any constitutional disturbance. The plaster of Paris bandages will not be removed, as everything appears to be in very good condition. The breast wounds and the hydrocele and hernia case will now be dressed, and after these dressings have been applied, I will proceed at once to perform the operation for to-day's clinics. (The dressings were removed in the presence of the class, and

primary adhesion was found in all the wounds.)

CASE I. The first case to-day is one of stone in the bladder, which I will remove by the supra-pubic operation. The patient, F. P., *æt.* 24, single, and a cigar-maker by occupation, gives the following history, which presents some characteristic symptoms:—

The family history is negative, with one exception, his mother having died of cancer. The patient states that he has been troubled since he was five years of age. At that age he first passed bloody urine, and he has passed blood since then. He always experiences pain on micturition, and frequently the flow of urine stops suddenly. This stoppage is accompanied by severe pain in the end of the penis, and this is followed by a slow dribbling of the remaining urine. He has had periods of variable length, the longest being two years, in which he has not suffered from symptoms of stone. His urine, as a rule, is filled with stringy mucus.

The pubes and hypogastrium having been shaved, the patient is anæsthetized, lying on his back with his buttocks slightly elevated. I insert into the rectum, in the grasp of the internal sphincter, a rubber bag, and distend it by injecting warm water (about 3xii). Next I throw into the bladder eight ounces of warm, weak solution of boro-salicylic acid to distend it. This new procedure has for its object the increase of the distance between the *symphysis pubis* and the anterior *cul de sac*, or pubo-vesical fold of the peritoneum. For it is through this space that we are to open the bladder without opening the peritoneal cavity. I now make my incision through the skin and cellular tissue from a point three inches above the symphysis, and extend it on to the front of the symphysis, exposing the *linea alba*. I now cut through the *linea alba* on a director between the pyramidales and recti muscles, dividing the transversalis fascia. I come upon a cushion of loose fat. If, as often happens, the pyramidalis muscle is exposed, by dividing the sheath of the rectus instead of going exactly through the *linea alba*, you must bear in mind that there is no posterior sheath to these

muscles in this locality, but merely the transversalis fascia. This fascia having been divided in either case, I tear through the underlying fat with two thumb forceps, the edges of the wound being retracted by my assistants. I have now exposed the wall of the bladder, with its veins and muscular fasciculi showing on the surface.

I now pass a silver catheter into the bladder and make its point push carefully the anterior wall of the bladder into the wound. If uncertain whether or not the peritoneum is out of danger, you may carefully observe whether you have two sliding surfaces lying over the front of the wound.

Having assured yourself that you have to do only with the wall of the bladder, you have it seized and held with two tenacula, while you make an incision between them into the bladder. Here, one is apt to be disconcerted by finding the mucous membrane of the bladder very thick. Now, taking a probe pointed bistoury, I continue the incision with caution down to the symphysis, never below, towards the urethra.

Next a stitch is taken in the bladder wall on each side of the incision, by which means the aperture may be conveniently held open. The finger is now introduced into the bladder, the stone found, and seized and removed with lithotomy forceps, since it is not so large as to necessitate crushing. The colpeurynter having been removed, a finger introduced into the rectum may facilitate your manipulation at this point. The stone being removed, a catheter is placed through the supra-pubic wound, which is then closed by deep sutures extending through the integument and muscles. Another catheter will be passed and retained in the urethra for forty-eight hours.

Supra-pubic lithotomy was first performed by Pierro Franco in 1561. The rectal air bag was advocated by Peterson, Gosselin and Bois. For some reason, the operation fell into disrepute, or at least disregard, from which it has been resented only recently by Garson, of the Royal College of Surgeons, of London, who first suggested the water-bag colpeurynter, and other experiments. It is to be, undoubtedly, the lithotomy of the future. It is especially

indicated by a large stone, a contracted pelvis, or joint trouble when the perineum cannot be exposed. The stone just removed weighs 1274 grs. Its greatest circumference is seven inches, and its least five inches.

CASE II. The patient before you now, J. S. by name, is 16 years of age, and has no occupation. His family and previous histories are good. His present trouble began three years ago, at which time he noticed a severe pain in the right side when he passed his urine. He also had sudden stoppage of the urine, accompanied by severe pain in the end of the penis, and continuation of the flow only after bending the body forward. He never passed any blood or mucus.

When we introduce a Thompson's searcher, a distinct click is heard by those sitting near. Passing in a grooved staff, we now perform the lateral operation. Pass in the forceps and by firm, slow traction, we see the stone removed. Now pass a chemise catheter into the wound and pack it with iodoform gauze. The catheter is to be removed in six hours. The stone weighed 604 grains.

(Fifth clinic.)

Gentlemen: In the clinic to-day, I will first dress before you the case of supra-pubic lithotomy which you saw operated upon last week.

The patient has been in a most satisfactory condition since the operation. Before removing the dressings, I desire to call your attention to an interesting point in connection with the convalescence of this patient. He has, as you observe, a well-marked urethritis, which began the day following the introduction and retention of the rubber catheter for perineal drainage. The catheter was aseptically clean when introduced into the urethra; but its presence in the urethra for several days has resulted in a catarrhal inflammation.

It is a traumatic urethritis, and I mention this complication, first to warn you against it in any similar case, and secondly to call your attention to a point of differential diagnosis. At a glance you would look upon this case as one of gonorrhœa, and did I not know the fact that it would be extremely unlikely that such a disease could develop under the cir-

cumstances, I might have been inclined to consider it a case of specific urethritis which had developed incidentally at this time. Our patient has been for several weeks in the public hospital ward, and has suffered from the torture of this large calculus. All the evidence, therefore, is against the specific origin of this urethritis. I requested Dr. Seymour Houghton to examine the discharge very carefully under the microscope. Dr. Houghton has had a good deal of experience at the Carnegie Laboratory, in staining specimens for the detection of micro-organisms. He reports that, after repeated trials, he has been unable to find the gonococci of Neisser, and this is the first specimen, out of a large number that he has examined, in which he has failed to discover the gonococcus.

I have seen recently, in private practice, a urethritis in a boy of ten years, and subsequently I was consulted in regard to a leucorrhœal discharge in the boy's sister, who was but eight years old. Though every evidence was in favor of the traumatic origin of the urethritis and vaginitis, yet the microscopical examination proved the specific origin of the trouble by the presence of gonococci. The boy finally admitted that he had contracted the disease from a woman, and that he had given the disease to his sister. I have seen a case of specific urethritis in another boy of eight years, who confessed that a woman had taken liberties with him. I mention these facts in connection with the complication in the case before us, to illustrate how easily the diagnosis can be positively made by the application of our knowledge of bacteriology, a science which holds important relations to the art of surgery.

Let us now recur to the patient; as you see, he is suffering from no constitutional disturbance. The dressings will now be renewed, and in another week, I trust, he will walk into the clinic, cured of his troublesome disease.

CASE I. The first case for operation to-day is one of supposed abscess of liver, with the following history: J. W. P., *at.* 29, a telegraph line-man by occupation, states that during a stay at St. Helena, six years ago, he contracted some disease characterized by severe

pain in the right side. He was told at that time that he had enlargement of the liver. The attack lasted two weeks. One week before admission to this hospital he had severe pain in the epigastrium, causing great difficulty in breathing, but with no elevation of temperature or chill. There is no history of injury. He has been in the Congo river district. While in the hospital he has suffered very little, and appears to be in good health. You can see an enlargement in the epigastrium over the left lobe of the liver. I plunge in a hypodermic needle, and as I withdraw the piston, you can see the barrel fill with pus. I now make an incision about two inches long over the point of greatest enlargement, carrying it directly into the liver, and you see the pus well up in the wound. Now we wash out the cavity thoroughly with Thierseh's solution, insert a drainage tube, and close the wound, dressing it antiseptically.

CASE II. The next case is one of lipoma of the neck (patient, M. K., female, age 60). You see a tumor over the left clavicular region. This tumor in size and shape greatly resembles a cucumber, and presents the following characteristics: It is soft, lobulated, moves freely under the skin, and is absolutely painless. It has been increasing slowly in size, since its appearance three years ago. The patient attributes it to a blow on the shoulder. I make an incision longitudinally over the tumor, dissecting up the integuments on either side. Now the tumor is completely enucleated, and I break down its final attachment and remove it. We will introduce a drainage tube, and close the wound with suture, applying the customary antiseptic dressing.

CASE III. The next patient (F. J., age 18) is suffering from a varicocele upon the left side. He was totally unaware of his trouble until he applied for a position in the navy, when he was refused on this account. I have decided to perform Sir Astley Cooper's operation, removing about an inch of the scrotum in this case. A quilled suture is used, and the drainage tube is allowed to project at either angle of the wound, the scrotum being then supported by a bandage.

CASE IV. This next patient (J. W., age 25, porter) is suffering from the same trouble as the preceding; but this case presents an interesting feature, because a distinct impulse is transmitted to the varicocele on coughing, which makes this trouble liable to be mistaken for a hernia. We will now perform Sir Astley Cooper's operation. A double row of sutures will be employed, and the scrotum will be held well up against the abdomen by a broad strip of adhesive plaster. Prof. Keyes will ligate the veins before you next month at his clinic, and you will then have had an opportunity of witnessing the several operations for this disease.

(Sixth clinic.)

Gentlemen: In the clinic to-day we will observe our usual custom and present the cases operated upon at the last clinic, and, having dressed them, we will begin the operations.

The case of abscess of the liver is doing well. He suffers no pain, has no constitutional disturbance, the discharge is very small, and to-day we will remove the drainage tube, as the cavity is nearly closed to the surface. The lipoma of the neck is, as you see, all healed by primary intention, and we will re-apply antiseptic dressings only because the wound is not sufficiently firm to allow the patient to go out of the hospital.

The first case of varicocele is healed; and it is a good test of antiseptic surgery to obtain primary intention in a scrotal wound. I can commend to you most highly the use of the second row of sutures in order to keep perfectly free from movement the edges of the wound.

The second case of varicocele is also healed by first intention, and this is a second successful test for antiseptic surgery. Remember, I told you in regard to varicocele, that as a rule a suspensory bandage was all that was necessary, and that only in exceptional cases should an operation be employed. The nature of the trouble makes it one which is likely to prey on the mind of the unfortunate sufferer, and quacks always treat it as a grave disease, which is likely

seriously to affect the patient. These sufferers have become almost insane. The regular profession should discountenance as a charlatan any physician who practices such attempts to prey upon the minds of young men. Atrophy of the testicle, although it is rarely produced by varicocele, must however be thought of in connection with the disease; and where there is any evidence of such a condition, an operation can be performed with propriety.

CASE I. The first case this afternoon is one of necrosis of the tibia; the patient, A. S., *æt.* 8, has a good family history. He has always enjoyed good health, until one year ago, when he struck his leg while playing. Shortly after, a painful swelling appeared over the crest of the tibia, accompanied by constitutional symptoms. An exploratory incision was made then, and about a pint of pus evacuated; this operation was followed by closure of the wound, with the exception of a small sinus which continued to discharge pus and pieces of bone at regular intervals. Now, making an incision about four inches long, just over the anterior surface of the tibia, I incise the periosteum and strip it up laterally. I see a sequestrum, surrounded by new bone. At the lower angle of the incision there is a piece of detached bone, and about the middle a collection of gelatinous material, filling in a small cavity which appears to lead to the epiphysis. Now, carefully gouging out all the necrosed bone, I pack the wound with iodoform gauze and allow it to heal from the bottom.

CASE II. The next patient (J. S., *æt.* 27, brakeman), while coupling cars, got his hand caught and received the injury which you now see. The whole hand is pulpified, circulation has been cut off from the fingers, and decomposition has set in already, as is manifested by the emphysematous crackling. I will amputate just above the wrist joint. I make a circular incision, and now two lateral ones and dissect up anterior and posterior skin flaps about two inches long; now I divide everything down to the bone, just a little below the limits of the flaps, dissect up the periosteum, divide the interosseous membrane, and saw

the bones across under continuous irrigation to prevent any circular necrosis, which Volkmann has shown may follow by rapid sawing, which acts like a cautery to the bone. The ends of the bones are now made smooth. I introduce a drainage tube and close the wound with a continuous suture. It will be dressed antiseptically and the stump placed on a palmar splint.

CASE III. We now have a case of condylomata of the penis. This patient (C. S., *æt.* 20, book-keeper) states that three months ago a small sore appeared on his foreskin. It spread slowly at first, but later on rapidly until the whole prepuce became involved in the warty growth. You can see the great increase in size, also the distinct warty appearance, and the foul-smelling discharge. Now, passing a bistoury I slit up the foreskin and with a pair of curved scissors I remove all of the prepuce which is the seat of the vegetation. Here is some of the disease on the glans which I will also snip off with scissors. I cover the whole with loose gauze and a bandage.

CASE IV. The next patient I will show you is P. F., *æt.* 13, who gives the following history: About seven years ago he was thrown down and received a fracture of the left scapula. Five years ago the arm began to shorten and a surgeon re-fractured the scapula. Shortly after, an abscess formed and discharged, leaving two sinuses, one near the coracoid process, the other on the upper portion of the arm posteriorly. Now, enlarging one of the sinuses and passing in my finger, I find it passes directly into the shoulder joint, in which I feel roughened bone. Excision of the joint is indicated certainly, but as the parent objects I will content myself, at least for the present, with enlarging the other sinus, passing a drainage tube through the joint, and applying the antiseptic dressing.

CASE V. This patient (V. S., *æt.* 38, a steamboat man by occupation) contracted gonorrhoea twenty years ago, and he has had repeated attacks since. He has had symptoms of stricture for fifteen years. He has used sounds at irregular intervals. Two weeks ago he had pain in the perineum and scrotum,

and on the day before his admission (to-day) the abscess also ruptured through the perineum.

Now placing the patient in lithotomy position, I make free incisions in serotum and perineum, and you see the urine and pus pour out of the infiltrated tissues. This will afford temporary relief.

(*Seventh clinic.*)

CASE I. Gentlemen: To-day you see the patient again, in whose case I made free incision of the perineum and scrotum, and you can see the marked improvement. Now I will perform the operation of perineal urethrotomy. I pass the urethrotome and afterwards a sound up to No. 19 English. Now I put a soft catheter into the bladder through the perineum and allow the wound to granulate and close.

CASE II. The next patient is J. M., *æt.* 50, married, by occupation a fireman.

Nine months ago, while he was going to a fire, the truck upset, and some part of the vehicle struck him on the ankle, producing a compound fracture, involving the ankle joint. This fracture was treated at the 99th Street Hospital. The wound only partially healed, leaving the sinus you see on the inner side of the right foot. Now, enlarging the sinus so as to allow the passing in of a scoop, we come in contact with dead bone, part of the *os calcis* and astragalus, which I now scoop

out. Having removed all the dead bone, and having made a counter opening on the opposite side of the foot, so as to drain directly through the joint, I will now insert a drainage tube, and dress antiseptically.

CASE III. The next case (L. C., *at.* 30, single, no occupation), gives a history of being thrown or falling from a railroad train in motion. The patient has just arrived in the hospital, with his head enveloped in bandage. We find a scalp wound on the top of his head in the median line. A fissured fracture also present about two inches long, and in the centre a punctured fracture. I will now apply a periosteal elevator and those who are near can plainly see several small spicules of bone, lying loose on the dura; these I remove with the forceps. After examining carefully the dura, I find it uninjured. The edges of the bone will be burnished and the wound will now be washed out with a solution of bichloride and, as oozing is rather profuse, I think it advisable to pack it with iodoform gauze and partially close the wound with catgut. The patient's pupils are normal and he presents no paralysis, or loss of sensation, although he has been slightly dazed since his admittance; his pulse and temperature are normal. He has also a fracture of the nasal bones.

This, gentlemen, will be the last operation in the clinic to-day.

